By Francis J. Crosson, MD

A New Moment in the History of Kaiser Permanente

The Formation of The Permanente Federation and the Permanente Company and the National Partnership Agreement

"The quality of care delivered at every site we call 'Permanente' must be of a level that we all can 'own' and be proud of."

Formation of The Permanente Federation and National Partnership Agreement mark a turning point in the history of Kaiser Permanente (KP) and will positively influence the future of Permanente Medical Groups. Understanding the genesis and nature of these two events is helpful for visualizing the KP of the next decade.

Background

The winter of 1996-97 saw a rite of passage for Permanente Medical Groups (PMGs) and a landmark point in the history of KP: Between December and February, the 12 PMGs formed common governance structure (The Permanente Federation), created a new national business entity (The Permanente Company), and signed a memorandum of understanding with Kaiser Foundation Health Plan (the National Partnership Agreement) to resolve a broad set of internal issues. Why did this happen, and what does it mean for the future of our organization?

On the surface, the story is simple. Early in 1996, KP began a new cycle of geographic expansion involving either merger or acquisition of health plans. Examples include the merger with Group Health Cooperative of Puget Sound (in the Pacific Northwest), acquisition of Community Health Plan (in New York) and acquisition of Humana (in Washington, DC). The case for new geographic expansion was compelling: consolidation of regional competitors into large national for-profit managed care organizations could eventually marginalize Kaiser Permanente. A sound case was made that to be a truly national organization, we need to extend our presence to other large population centers, especially in the eastern U.S.

The new expansion quickly raised basic questions: Was Kaiser Foundation Health Plan (KFHP) expanding, or was KP expanding? If expanding, then what should be the nature of the "Permanente" side of this effort? How could 12 independent PMGs manage such a national undertaking?

Another set of issues was also being formulated. In 1996, a combination of aggressive pricing and operational inefficiencies had already created operating losses for some KP Regions. Intermittent operating losses have adversely affected KP for years but in the new competitive environment were of more concern than ever. There arose a new need to fix underperforming areas quickly so that we all could thrive together.

Also, the outside world was becoming more hostile to so-called managed care organizations, a category into which we continue to be placed. As several well-publicized charges of poor quality of care have made clear, we are under a national microscope. If it was not true before, we now know that the reputations of all Permanente physicians are linked together in the national mind. The quality of care delivered at every site we call "Permanente" must be of a level that we all can "own" and be proud of.

Both these issues—improvement of performance and quality of care wherever needed—called for the 12 Permanente Medical Groups to help each other. In 1996, however, no demonstrable common will to do so was evident, and no defined organization or set of resources were available for this purpose. If organizations such as Phycor and MedPartners Mulliken could create national physician business entities, why not Permanente?

These were the issues facing the Permanente Medical Directors in 1996. To investigate the options and recommend a solution, the Executive Committee of the Medical Directors, chaired by Dr. Harry Caulfield, appointed a small group of physicians called the Business Support Work Group. The group included me, Dr. Allan Weiland (an obstetrician-gynecologist and Medical Director of KP-Northwest), Dr. Ian Leverton (a surgeon and Executive Director of Permanente Interregional Consulting), Dr. Irwin Goldstein (a pediatrician and Associate Medical Director of Southern California PMG), and Dr. Bruce Perry (a family practitioner and Executive Medical Director of Southeast PMG). We worked intensively during Summer and Fall of 1996, and in October presented to the Medical Directors a set of recommendations calling for creation of a PMG federation, a KP national business entity, and comprehensive negotiations with KFHP.

The Permanente Federation

A federation is hardly a new idea: Our country is governed by a federalist system in which certain authority is vested centrally and in which certain authority is retained locally. The question was, What central authority was needed to address common concerns, and what was best left to each PMG? The Work Group examined—and then rejected—the idea of creating a single medical group, an economic entity which would negotiate nationally with Kaiser Foundation Health Plan for our annual financial agreement (the basic contractual payment [BCP], which is contained within a Medical Service Agreement [MSA]). Creating a single, unified medical group was not thought to be either needed or desirable for solving the issues facing us in 1996.

Ultimately, on January 6, 1997, we created The Permanente Federation, whose "constitution"—the

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Articles of Federation—installed in the Federation governance central authority to further four purposes. They are:

- Joint accountability for quality of care
- Joint accountability for business performance
- Joint responsibility for geographic expansion
- Joint management of business ventures.

Each of these purposes relates to solving the issues which faced the Medical Directors earlier that year: improving financial performance where needed, improving quality of care where needed, and creating new KP business competencies to support and expand the KP organization.

The Articles of Federation created for the new Federation a balanced and representative governing body—the Executive Committee—consisting of an Executive Director and four Medical Directors. Executive Committee decisions are subject to review by the Medical Directors (Fig. 1) as a group. All this and more is delineated in the Articles of Federation and in the Federation Operating Agreement, which were approved in December 1996 by all Medical Directors and Permanente Boards of Directors and are available for anyone to read.

The first meeting of the Executive Committee was convened on February 5, 1997. The first four members of the Executive Committee were Dr. Oliver Goldsmith (Chair), a gastroenterologist and Executive Medical Director of Southern California PMG; Dr. Harry Caulfield, a cardiologist and Executive Director of The Permanente Medical Group (TPMG); Dr. Allan Weiland; and Dr. Adrian Long, an emergency physician and Executive Medical Director of the Mid-Atlantic PMG. In April 1997, I was appointed and approved as Executive Director and fifth member of the group.

The Permanente Company

Early in the planning of the Federation came the realization that managing both governance and business issues would be too complex for a single organizational unit. A national Permanente business would need to serve the needs of the sponsor PMGs while maintaining a degree of independence not typical of physician-directed businesses. Thus was born The Permanente Company (PermCo); a limited-liability company owned by the Federation's member PMGs and registered in January 1997. PermCo has a separate Board of Directors who are confirmed by vote of the Medical Directors. As Executive Director of the Federation, I serve as the Chair of the PermCo Board. Other current members are Irwin Goldstein and Bruce Perry; Toby Cole, an internist and Executive Medical Director of the Colorado PMG; and Robert Ridgley, Chairman of Northwest National Gas Company and a member of KFHP's Board of Directors. PermCo's Chief Executive Officer (CEO) and one additional Board member remain to be appointed.

What is the difference between the Federation and PermCo? They are separate but related entities, each with a distinct purpose (Fig. 2): The Permanente Federation develops policy and provides governance and oversight for the purposes outlined in the Articles of Federation; PermCo builds and manages the business functions of the Federation.

Fig. 1. The Permanente Federation Medical Directors. From left to right. Including Medical Group (back row) W. Harry Caulfield, MD, TPMG [Executive Committee member]; William Gillespie, MD, Texas; Melvin Mulder, MD, Ohio; Francis (Jay) Crosson, MD, Permanente Federation [Executive Committee member]; Adrian Long, MD, Mid-Atlantic [Executive Committee member]; (middle row) Donald McGuirk, MD, Mid-America; Peter Lee, MD, North Carolina; Oliver Goldsmith, MD, Southern California [Executive Committee member]; Stacy Lundin, MD, Northeast; Bruce Perry, MD, Southeast; Allan Weiland, MD, Northwest [Executive Committee member]; (front row) Toby Cole, MD, Colorado; Michael Chaffin, MD, Hawaii

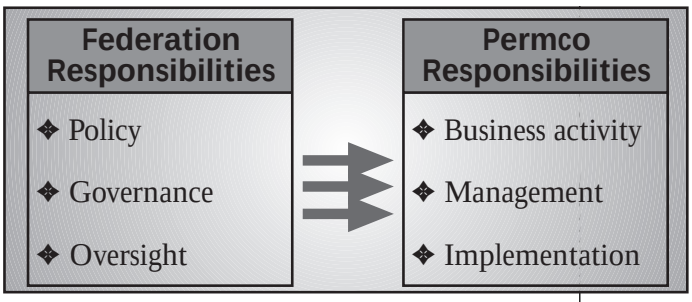

Fig. 2.

What business functions was PermCo intended to build? First, PermCo will build physician practice management capabilities—services (such as supplied by Phycor or MedPartners Mulliken) needed to improve Permanente practice and to create new Permanente delivery systems in expansion areas. PermCo teams initially began helping to improve Permanente practice in North Carolina and Ohio. Working with KFHP, PermCo teams began exploring expansion opportunities in Chicago and New York in March 1997.

Second, PermCo will build a new capability to enable PMGs to explore business diversification opportunities. An advisory group including physicians from each PMG began working last Fall to examine sound business opportunities which could strengthen Permanente capabilities, further the mission of our organization, and provide new employment opportunities for PMG physicians and an opportunity for them to build value over time.

Third, PermCo will be the place where Permanente physicians build information systems to provide the clinical and business support we will need in the future. In partnership with KFHP, a team of Permanente medical informatics specialists will direct the multiyear national project designed for this purpose. We will hear more from PermCo in the future.

Fig. 3. Signatories to the National Partnership Agreement Memorandum of Understanding, February 5th, 1997. From left to right, including titles:
Back Row: Jerry Fleming, Senior Vice President, Administrative Services, California Division, Kaiser Foundation Health Plan; Jim Williams, Senior Vice President, Strategic Development & Human Resources, Kaiser Foundation Health Plan; Toby Cole, MD, Executive Medical Director, Colorado Permanente Medical Group; Allan Weiland, MD, Medical Director, Northwest Permanente; Richard G. Barnaby, President and Chief Operating Officer, Kaiser Foundation Health Plan; Irwin Goldstein, MD, Associate Medical Director, Southern California Permanente Medical Group; Ian Leverton, MD, Executive Director, Permanente Interregional Consultants; Adrian Long, MD, Executive Medical Director, Mid-Atlantic Permanente Medical Group.
Front Row: Susan Porth, Senior Vice President, Corporate Services and Chief Financial Officer, Kaiser Foundation Health Plan; Francis J. Crosson, MD, Executive Director, The Permanente Federation; David M. Lawrence, MD, Chairman & Chief Executive Officer, Kaiser Foundation Health Plan; W. H. Caulfield, MD, Executive Director, The Permanente Medical Group; Oliver Goldsmith, MD, Executive Medical Director, Southern California Permanente Medical Group; Robert Crane, Senior Vice President, Interdivisional Services, Kaiser Foundation Health Plan.

The National Partnership Agreement

Our 50 year partnership with KFHP in recent years has been strained: Kaiser Permanente has not been immune from market pressures, and this has taxed the patience of both partners. Some felt that mutual exclusivity was threatened by KFHP'S acquisitions. By mid-1996, the processes for coordinated national decision-making were not functioning smoothly. In the Fall of that year, Harry Caulfield as Chair of the medical directors and David Lawrence as CEO of KFHP Health Plan commissioned a group—the National Partnership Agreement Group (NPAG)—to create an agreement which would revitalize the partnership and lead to a more confident organization, improve organizational performance, and help reestablish Kaiser Permanente as the standard for health care delivery in this country. The group consisted of myself, Goldstein, and Weiland representing Permanente; and Jerry Fleming, Robert Crane, and Jim Williams, all Vice Presidents of KFHP. NPAG met intensively over a three month period from mid-November 1996 to early February 1997.

On February 4 and 5, 1997, the leaders of both the Permanente Federation and KFHP met in San Francisco to receive NPAG's recommendations. On February 5, all parties (Fig. 3) signed a memorandum of understanding which, in May 1997, led to a final agreement and contract between the parties.

The National Partnership Agreement established:

- a joint KP statement of purpose (aspiration)
- the contractual basis for national mutual exclusivity
- agreement to build a common national strategy, directed by a joint strategy group called the Kaiser Permanente Partnership Group (KPPG)
- joint decision making for geographic expansion, information technology development, business venture development, and other policy areas
- the Care Management Institute to develop national disease management capabilities

- a service contract between KFHP and PermCo for geographic expansion, performance improvement, and information technology development.

The National Partnership Agreement became effective on June 1, 1997. KPPG began to meet in July 1997, and most of the joint decision-making bodies will be in place by Fall. As strange as it might seem for an organization as large and as old as ours, this agreement marks the first time that many of these issues have been formally addressed and codified. It is an important start to an improved Kaiser Permanente. ❖

By Francis J. Crosson, MD

Creating the Future of Kaiser Permanente: Critical Strategic Choices

The world of medicine is changing around us. Some say it is falling apart. Our profession, having lost the economic reins of medicine, is in chaos. Most of us joined Kaiser Permanente because we thought it offered something different. For many it was safety, stability and the freedom to practice our profession free from the business concerns of medicine. Some feel that those qualities have been lost in Permanente at present. Some is perception, some is fact.

How should we view the future then, for Permanente physicians? Should we push to expand Kaiser Permanente geographically or should we circle our wagons around our existing Medical Groups, work hard, and hope for the best? What, of value, actually have we built all these years? Are group practices outmoded? Are networks the future recipe for success? Does Kaiser Permanente stand for anything special? Should we continue to strengthen our partnership with Kaiser Foundation Health Plan or build a future based on a friendly but merely contractual relationship with them? Does anyone outside of our organization care any more what we do or don't do in Kaiser Permanente?

The creation of the Federation and PermCo, and the National Partnership Agreement with Health Plan are first steps along the way to answering these questions and creating a strategic plan. The plan will determine the degree of success of Kaiser Permanente and the nature of our professional lives in our Medical Groups.

Let's examine some of the business and professional issues that will need to go into making up that strategic plan.

Geographic Expansion

The case for expansion seems simple. We have always expanded Kaiser Permanente. We believe we offer something of value to people. As many people as possible ought to have access to us. Furthermore, growth keeps us vibrant. It provides an appropriate mix of members and allows us to hire new physicians and employees with important skills. It provides for economies of scale that improve our efficiency.

Also, as the argument goes, the best defense is a good offense. We are facing ever larger competitors. If we fail to grow sufficiently, we may be disadvantaged in the future in many ways that we cannot predict now. In addition, some regional and national employers are asking us to provide broader geographic coverage or lose contracts for their members.

It is not so simple. Expansion costs money which could be used to run ongoing operations. It also requires a lot of management time and attention, which is currently in short supply. In addition, in parts of the country, successful growth is seen to be related to the "choice" issue. We know we need to excel in price, access, service and quality to succeed. In some places, however, the perception that our group model does not allow members sufficient choice of physicians has hindered our growth. The "network" model of care has seemed more attractive because, in addition to greater perceived choice, it comes with lower development costs.

But if Kaiser Permanente evolves by network development, will it still be Kaiser Permanente or something else? What characteristics does a Permanente delivery system have to have to retain the essence of the special value that Permanente physicians bring to Kaiser Permanente and its members?

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Permanente Practice

Despite our flaws, we have gotten it right for years. Permanente Medical Groups have shown that physicians can successfully manage the quality and costs of health care and do so on a sustained basis. We do this by creating an environment in which physicians can coordinate member care without undue interference. This is not an accident. It happens because we have built the solid foundation that allows it to happen, one doctor, one patient at a time. Our strength is appropriate *Coordination of Care*.

The base of the foundation of that strength is the principle of *Group Responsibility*. A group of physicians share responsibility for a group of members. This responsibility includes the quality of care, the quality of service and the cost of care, because ultimately the costs are borne by the members. As individual physicians, then we have to worry not only about what we do for each member but also how we organize ourselves to care for everyone who is a Kaiser Permanente member. We work together for the good of these people. We don't compete with each other. We don't seek advantage over each other specialty by specialty.

In order to manage our responsibilities, we have created *Self-Governance*. Group decisions are made by representative processes. All of our physicians have the right to a voice in Group affairs and to economic and professional due process. This is the second foundation building block.

Only a self-governing group of physicians is capable of *Self-Management*. Self-management means that Permanente physicians decide the basis for the care of each patient, together with that patient and usually on the spot. There are no insurance clerks to call for permission to hospitalize our patients in Permanente practice. In fact, no insurance company at all stands between the doctor and the member. We create our own drug formularies and our own guidelines based upon what is scientifically correct and up to date.

If you believe that this model of Permanente Practice is correct, and is what separates us from our competitors, then we should not lose this foundation. It means that as we redesign ourselves and design the future expansion of Kaiser Permanente, we must continue to organize our delivery system according to these principles. Does that imply only a closed panel group model? Not at all. But it does mean that group practice should remain the core of Permanente Practice. Network arrangements should be concentrated and focused on physicians willing to develop long-lasting, significant and special relationships with us and our patients. Several of our Medical Groups are currently developing just such network models—ones that incorporate the elements of Group Responsibility, Self-Governance, Self-Management and Coordination of Care. We are still learning how this will really work outside of the pure group setting. But I believe that there are many physicians in new areas of the country, aghast at the nature of the worst of managed care, who would love to ally with the physicians of Permanente. We could help our profession by demonstrating that ethical physician-led delivery models can be successful enterprises. We may only need to lead the way.

The Value of Kaiser Permanente

For fifty years we have had a partnership with a not-for-profit organization called Kaiser Foundation Health Plan. It has not always been an easy relationship. Recently the partnership has been quite strained by the economic pressures on the health care industry. Is this relationship worth preserving or is it an anachronism in the world of health care high finance? Some medical groups such as Mullikin have turned to Wall Street and investors for the resources to expand and improve. Should Permanente do so also?

Health care is different from other businesses. It affects everyone in the society and in a deeply personal way. The country is just now coming to realize its discomfort with the real mix of medicine and profits, Wall Street style. Columbia HCA, once the miracle of business discipline, is now a public spectacle of greed and malfeasance. Physician-led, investor-owned, national corporations may be next.

The partnership of strong Medical Groups and socially conscious not-for-profit Health Plan has been a winning combination in the past. It has provided good care for the members, stable and satisfying professional careers for the doctors and return of excess revenue to those members either in better facilities and equipment or reduced rates. Both the Health Plan and The Permanente Federation need to remember the moral strength we derive from this commitment to the not-for-profit principle, both internally in how we conduct ourselves and externally in how we are viewed by society. Ours may not be the only good model but it is an ethically sound one that many will wish to be associated with now and in the future.

Developing Our Strategic Plan

One result of the National Partnership Agreement (see accompanying article) was the creation of the Kaiser Permanente Partnership Group (KPPG). The KPPG consists of the senior national leaders of both Kaiser Foundation Health Plan and The Permanente Federation. Its primary job is strategy development. The KPPG is chaired by Dr. Oliver Goldsmith, a gastroenterologist, and Executive Medical Director of the Southern California Permanente Medical Group. Dr. Allan Weiland, an obstetrician-gynecologist and Executive Medical Director of the Northwest Permanente Medical Group and Mr. Robert Crane, Vice President of Kaiser Foundation Health Plan have created an intensive work process designed to resolve the issues discussed above as well as others. The work is well underway.

What can each of us do when we realize the organization is faced with such critical and difficult issues to resolve? The most important quality for all of us to have right now is self-confidence. We are a great and noble organization. What we have created is special and good. We cannot let our flaws and mistakes and the criticism of others weaken our convictions about the basic value of Kaiser Permanente and Permanente Practice. With self-confidence and hard work we will not fail. ❖